TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CLINICS OF NORTH TEXAS

Respondent Name
PHOENIX INSURANCE CO

MFDR Tracking Number
M4-17-0074-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
September 12, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I mailed the original bill on 08/25/2015 and have appealed the claim on several date however I am getting the bill denied. I have sent in information to the visit being necessary. I have contacted Traveler's regarding the denial as the claim that is being referenced in the insurance system is for a different date of injury so the claim number that is being used is incorrect. I was asked to submit the claim with the correct information however it still was denied, if you need anything else or have any comments do not hesitate to contact me."

Amount in Dispute: $159.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider alleges they are entitled to reimbursement for the dispute services. The Provider has waived the right to reimbursement under Rule 133.307 as they did not file their Request for Medical Fee Dispute Resolution with the Division within one year of the date of service as required by Rule 133.307(c)(1). The date of service at issue is 08-20-2015, which required the Request to filed with the Division no later than 08-20-2016 (a Saturday, extending the deadline to 08-22-2016). As noted by the Division date stamp, the Request was received on 09-12-2016, or 21 days late. Consequently, this Request for Medical Fee Dispute Resolution should be dismissed."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 20, 2015	CPT Code 99213	$159.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied suing remittance advise remarks codes whenever appropriate
   - W3 – Additional payment made on appeal/reconsideration
   - P12 – Workers compensation jurisdictional fee schedule adjustment
   - 29 – The time limit for filing has expired
   - 50 – These are non-covered services because this not deemed a medical necessity by the payer

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The date of the services in dispute is August 20, 2015. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on September 12, 2016. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		10/6/16
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.